STAR Kids

SPECIAL AND/OR TECHNOLOGY ASSISTED RESOURCES

Georgia Emergency Medical Services for Children

STAR Kids

Special and/or Technology Assisted Resources

GEORGIA EMERGENCY MEDICAL SERVICES FOR CHILDREN

Thousands of children and adolescents each year are rushed to emergency departments following serious injury and illness. The National Center for Health Statistics reports approximately 20,000 of these children lose their lives and another 50,000 are permanently disabled.

The needs of all children including those with special health care needs must be considered when preparing for and responding to severe illness or injury. Children with special health care needs (CSHCN) have medical conditions that could place them at greater risk during a medical emergency. In addition, some children that acquire disabilities as a result of their injury or illness may need rehabilitation and other services that require special coordination of resources. It is important that everyone involved, including parents, teachers, bystanders, EMTs, paramedics, nurses, doctors and specialists are aware of a child's special needs, both in preparing for and surviving a medical emergency. Families of children with special needs should participate in the development of a written emergency plan which is easily accessible and include provisions for any special training for emergency medical personnel, family members and others who may be called on to provide emergency care for the child.

The Pre-hospital Guidelines Sub-committee of the Georgia Emergency Medical Services for Children developed the STAR Kids Program based on recommendations from the federal Maternal Child Health Bureau, American Academy of Pediatrics and the American College of Emergency Physicians to ensure the emergent special needs of Georgia's children are met.

The STAR Kids Program is designed as an emergency care plan. This parent/patient information folder is provided by the Georgia Emergency Medical Services for Children and includes:

- Information to parents or caregivers on how to contact their local emergency medical service provider to arrange for an in home pre-planning session to determine the best means of access, special equipment needs, etc.
- A clinical information page to complete (with assistance by the child's physician) about the child's medical condition, needed medications, and proper emergency intervention strategies.
- A listing of recommended groups and individuals who should know about the existence of the emergency care plan.

Regional EMS Offices

The Emergency Medical Services (EMS) System in our state is maintained and regulated through the Division of Public Health, State Office of EMS and ten Regional EMS offices. Each of our 159 counties is designated to one of these regional offices. In the following pages you may locate your county and determine what EMS Region covers your area. Listed below is a complete listing of contact information for each Regional EMS office.

Northwest Georgia Region I EMS – Health District 1-1 and 1-2

Program Director:	**David Loftin**
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North Georgia Region II EMS – Health District 2

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Metro Atlanta Region III EMS – Health Districts 3-1 to 3-5

Program Director:	**Marty Billings**
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West Georgia Region IV EMS – Health District 4

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Central Georgia Region V EMS – Health District 5-1 and 5-3

Program Director:	**Chris Threlkeld**
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East Central Georgia Region VI – Health District 6

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West Central Georgia Region VII EMS – Health District 7

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Southwest Georgia Region VIII EMS – Health District 8-1 and 8-2

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Southeast Georgia Region IX EMS – Health District 9-2 and 9-3

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Northeast Georgia Region X EMS – Health District 10

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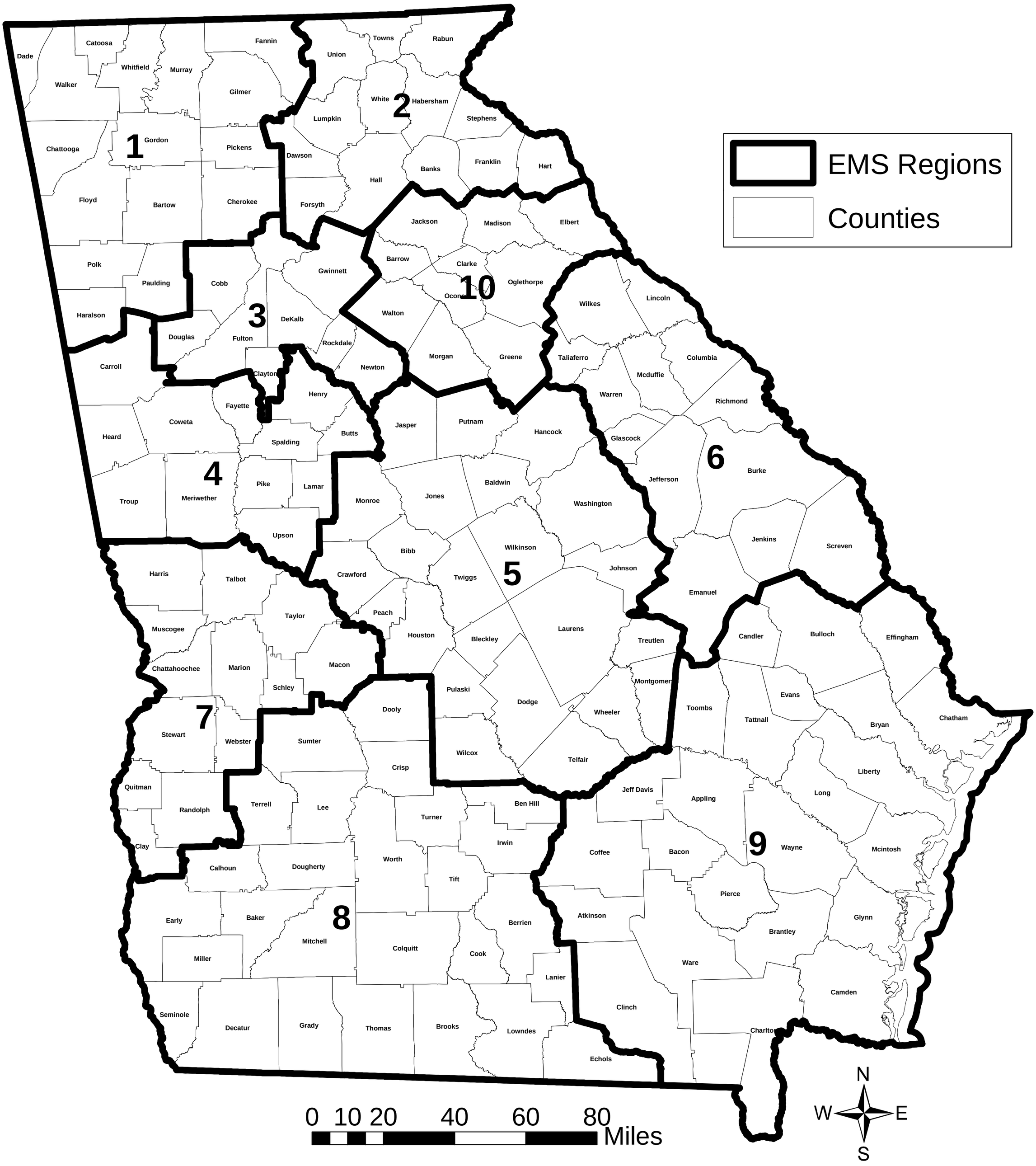
Emergency Medical Service Regions, 2003



Georgia Department of Human Resources
Division of Public Health
Office of Health Information & Policy

Created: March, 2003
Source: EMS Regions, 2003
Projection: UTM 1983, Zone 16

Pre-Planning Session

Children with special needs and equipment are sent home from the hospital much earlier than in the past, with recent advancements in technology enabling them to be more active both in school and the community. With this newfound freedom comes a responsibility for families and communities to be more prepared than ever for medical emergencies.

The following are suggestions, which should be discussed with your local EMS provider during the pre-planning session:

- Introduction of the child, siblings, family, or caregivers to the EMS providers
- Location of the child in the home
- Entrance and exit points for access with emergency equipment/personnel
- Barriers in or around the home which may delay or impede access or emergency care
- Training/in-service on any specialized medical equipment in the home
- Transportability of any specialized equipment or supplies for the child
- How and when to update any new or additional medical information
- Language spoken by primary care providers and parents

The pre-planning session should be tailored to the specific needs of the child. Any concerns or issues regarding the care or transport of the child in an emergency should be discussed with the EMS provider.

Concerns or Issues Discussed

Recommended Groups/Individuals

Identified groups or individuals to notify about the child's emergency care plan include,

- Communication/911 Centers
- Emergency Medical Services
- Fire Departments
- Utilities Companies (gas, electric, telephone, etc.)
- Education and Health Service Department of the child's school
- Specialty physicians
- Primary physician
- Therapists
- The child's family

Additionally, families should submit notification letters to local utility companies and emergency services to inform them of the child's special health care needs and what should be done in the event of a crisis.

Local EMS providers can facilitate the establishment of a network among these individuals and help educate all participants about their roles during an emergency involving a child with special health care needs.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

INFORMATION FOR THE INJURY PREVENTION COMMUNITY

by: Injury Prevention for Children with Special Health Care Needs Work Group, Emergency Medical Services for Children Program

Introduction

In 1996, the Emergency Medical Services for Children (EMSC) Program took a leadership role in injury prevention for children and adolescents with special health care needs. At that time, little was known about the epidemiology of injury for children with special needs and the risk factors associated with these injuries.

To improve our understanding of this issue, EMSC staff requested data from the National Pediatric Trauma Registry. This data, while not population-based, clearly identified trends for children with pre-existing conditions at the time of injury and only tracks children admitted to a Level 1 Trauma Center.

The data showed that children with pre-existing *chronic illness,* which includes children diagnosed with asthma, diabetes, and seizure disorders, are at the same risk of injury as children without chronic illness. Children with pre-existing *physical limitations* appear to have some special issues related to injury. However, children with pre-existing limitations in the *cognitive, social, and emotional categories* had a significantly higher rate of injury than their peers without limitations.

This data, coupled with information from teachers and injury prevention specialists, indicates that children and adolescents with special health care needs are at greater risk for injury. Additionally, parents of special needs children report that parents of healthy children receive more general injury prevention messages about subjects like fire and burn prevention, motor vehicle safety, fall prevention, and materials about safe home, work, and community practices.

To address this deficiency, the EMSC Program organized the *Injury Prevention for Children with Special Health Care Needs Work Group.* This group includes representatives from the injury prevention, health, rehabilitation and disability communities. The goals of the group are to build a bridge between the injury prevention, health, rehabilitation, and disability communities and to provide additional data sources, including population-based data, to improve the understanding of injury risks for children with special health care needs.

The information provided below is intended to help advocates, parents, and local organizations take an active role in promoting and practicing safety for ALL children.

Defining Children and Adolescents with Special Health Care Needs

Children with special health care needs are currently defined as "those children who have or are at increased risk for a chronic physical, developmental behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally" (Pediatrics, 1998). This definition includes children with disabilities.

Instead of referring to a person as being "handicap", many observers are recommending use of the term "social participation problems" to identify individuals that may have difficulty coping with the environment or shared activities with others.

Children with special health care needs are classified by both diagnoses and functional capabilities. The following are key issues identified for special needs children.

Key Issues Related to Diagnosis

- Type of health condition in need of special health care (cerebral Palsy, arthritis, brain injury, spina bifida, mental retardation, attention deficit hyperactivity disorder, autism, etc.)
- Chronicity of health condition
- Degree of severity of health condition
- Impact of health condition on the overall function of the child
- Recommended interventions:
  - Type
  - Frequency
  - Source of assistance and by whom
  - Cost to the agency and the family
- Prognosis for correcting the health condition

Key Issues Relating to Functional Capacity

Degree of limitation in function as it relates to activities of daily living (eating, dressing, walking, etc.)

- Impact of health condition on accessibility
- Impact of health condition on social participation
- Prognosis for reducing or eliminating functional limitations

Integrating Children and Adolescents with Special Health Care Needs into Injury Prevention Programs

Regardless of special health care needs, all children and adolescents and their families must learn how to prevent the incidence or reduce the risk of injury. Linkages between childhood injury prevention educators and health, rehabilitation, and community providers should be established in both health care and community settings (childcare, schools, etc.) Representatives from specialty areas should be involved in child injury prevention efforts and in assessing current injury prevention education practices for children with special health care needs. Primary care providers, including pediatricians and family practitioners, are excellent partners for providing injury prevention education to children with special needs. Also, state agency programs for children with special health care needs and agencies working on injury prevention are excellent resources for integrating special populations into injury prevention programs.

For persons with special needs, receiving information on how they can prevent injuries can be empowering. Instead of others "doing" for them or "serving" them, the focus, instead, is on providing tools, information, and education resources so they can help themselves maintain a healthy, safe, and productive life. Professionals, family members, and other care providers should use their expertise, experience, creativity and compassion to create approaches, educational resources, and tools that teach important safety and self-protective skills to children with special health care needs..

Sensitivity and Family-centered Approaches

By understanding the unique needs of CSHCN, injury prevention professionals can identify resources and educational approaches that are culturally appropriate and family-centered. Family-centered approaches acknowledge that parents should be involved in the care giving decisions that affect their children.

Families of children with special needs have been advocates for family-centered medical care for many years. Their activities, which are now referred to as "the parent movement," have established collaborative relationships between parents and the medical community. As more families succeed in making changes at hospitals, other types of health care services have begun to progress in understanding and implementing family-centered systems and approaches.

Key elements of family-centered care were spelled out in a U.S. Department of Health and Human Services document:

- Recognition that the family is the constant in the child's life while the service systems and personnel within those systems fluctuate.
- Facilitation of parent/professional collaboration at all levels of health care; care of an individual child; program development, implementation and evaluation.
- Sharing of unbiased and complete information with parents about their child's care on an ongoing basis in an appropriate and supportive manner.
- Implementation of appropriate policies and programs that are comprehensive and provide emotional and financial support to meet the needs of families.
- Recognition of family strengths and individuality and respect for different methods of coping.
- Understanding and incorporating the developmental needs of infants, children, adolescents, and their families into health care delivery systems.
- Encouragement and facilitation of parent-to-parent support.
- Assurance that the design of health care delivery systems is flexible, accessible, and responsive to families. (USPHS, 1987).

Partnerships

The injury prevention community has a broad spectrum of information beneficial to children with special health care needs. The members of the rehabilitation and disability communities (children, families, and providers) have a wealth of knowledge about the challenges associated with special heath care needs, functional concerns, risk factors, and recognize the psychosocial implications for children with special health care needs. Therefore, it is imperative that the injury prevention and medical communities work together to maximize the opportunities to promote injury prevention for special needs children.

–WHO –

Consumer/Advocacy Groups: These groups represent individuals with specific diagnoses. Examples may include the Spina Bifida Association of America, the United Cerebral Palsy Association, the Brain Injury Association, Learning Disability Association, the American Diabetes Association, and Family Voices.

Professional Organizations: These organizations represent the providers who serve children with special health care needs. Professional organizations are often active in creating and disseminating information and materials that assist providers with specific topics. Professional organizations also are active in developing practice guidelines that can be implemented at the local,

state, and national levels. Examples include the American Physical Therapy Association; the American Speech, Hearing, and Language Association: the National Association of School Nurses; and the American Academy of Pediatrics. Public health professionals can also be reached through the local and state health agencies that serve families of children with special health care needs.

–WHERE –

Children with special health care needs are involved in many programs in the community. These programs include: special education, rehabilitation services, rehabilitation hospitals, children with special health care needs clinics (sometimes referred to as Children's Rehabilitation/Medical Services), Shriner's hospitals and community therapeutic recreation programs. It is important that injury prevention professionals network with the leaders of these programs to develop effective injury prevention interventions.

Primary care providers can be contacted through state professional organizations and conferences. Local parent groups and state parent organizations are another avenue for reaching this special population.

–WHAT –

The following is a list of activities that can improve collaboration between the injury prevention and medical communities:

- Make a presentation on injury prevention for children with special health care needs at a conference.
- Invite a consumer/family representative to participate on an injury prevention coalition.
- Invite a family member or provider to help develop injury prevention materials that are targeted to families of children with special health care needs.
- Ask someone from one of the aforementioned professional groups to help modify existing injury prevention strategies to include children with special health care needs.
- Work in partnership with the disability community to develop an injury prevention program with interventions tailored to address specific functional limitations, social relationships, and environmental hazards (i.e. mobility, cognitive, behavioral, etc.).

–HOW –

- Contact the state/national office of a consumer/ professional organization and ask for an appropriate local/state contact in the disability community.
- Call your local contact to schedule a meeting to discuss collaboration.
- Explain your interest in injury prevention for children with special health care needs.
- Take sample injury prevention resources.
- Discuss current injury prevention interventions.
- Invite the new contact to join an existing injury prevention coalition.
- Discuss the opportunities to develop and disseminate injury prevention programs and initiatives to families of children with special health care needs.
- Develop a strategy for ongoing collaboration.

This framework was developed by the Injury Prevention for Children with Special Health Care Needs Work Group. The Work Group includes representatives from the following agencies and organizations:

- American Academy of Pediatrics,
- American Speech-Language-Hearing Association,
- Center for the Prevention of Disabilities
- Children's Safety Network
- EMSC National Resource Center
- Family Voices
- Maternal and Child Health Bureau, Health Resources and Services Administration
- Riley Hospital for Children at Indiana University
- National Highway Traffic Safety Administration
- National Safe Kids Campaign
- Spina Bifida Association of America
- TBI Technical Assistance Center
- University of Pennsylvania.

References

Pediatrics, Vol. 102, No. 1, 1998: 136-40.

USPHS. Surgeon's General Report, 1987. U.S. Public Health Service, U.S. Department of Health and Human Services, Washington, DC.

INJURY PREVENTION INFORMATION FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

by: Injury Prevention for Children with Special Health Care Needs Work Group, Emergency Medical Services for Children Program

Introduction

In 1996, the Emergency Medical Services for Children (EMSC) Program took a leadership role in injury prevention for children and adolescents with special health care needs. At that time, little was known about the epidemiology of injury for children with special needs and the risk factors associated with these injuries.

To improve our understanding of this issue, EMSC staff requested data from the National Pediatric Trauma Registry. This data, while not population-based, clearly identified trends for children with pre-existing conditions at the time of injury and only tracks children admitted to a Level 1 Trauma Center.

The data showed that children with pre-existing *chronic illness,* which includes children diagnosed with asthma, diabetes, and seizure disorders, are at the same risk of injury as children without chronic illness. Children with pre-existing *physical limitations* appear to have some special issues related to injury. However, children with pre-existing limitations in the *cognitive, social, and emotional categories* had a significantly higher rate of injury than their peers without limitations.

This data, coupled with information from teachers and injury prevention specialists, indicates that children and adolescents with special health care needs are at greater risk for injury. Additionally, parents of special needs children report that parents of healthy children receive more general injury prevention messages about subjects like fire and burn prevention, motor vehicle safety, fall prevention, and materials about safe home, work, and community practices.

To address this deficiency, the EMSC Program organized the *Injury Prevention for Children with Special Health Care Needs Work Group.* This group includes representatives from the injury prevention, health, rehabilitation and disability communities. The goals of the group are to build a bridge between the injury prevention, health, rehabilitation, and disability communities and to provide additional data sources, including population-based data, to improve the understanding of injury risks for children with special health care needs.

The information provided below is intended to help advocates, parents, and local organizations take an active role in promoting and practicing safety for ALL children.

Magnitude of the Injuries

Injuries are the leading cause of death and disability among children under the age of 20 in the United States. In 1995, more than 18,000 children under the age of 20 in the United States died from injuries. Nearly 180,000 children were permanently disabled (Centers for Disease Control and Prevention, 1998). Each year, more than 22 million children age 19 and under sustain injuries serious enough to require medical attention. (Weiss et al, 1997).

In general, children and adolescents are primarily at risk of injury-related death from motor vehicle crashes that include children as occupants, pedestrians, and bicyclists; drownings; fires and burns; suffocation; poisoning; choking; firearm-related injuries; falls; and for injuries sustained at work. Injury rates vary with a child's age, gender, race, and socioeconomic status. Children that are younger, male, part of a minority group, or in a low socioeconomic group suffer disproportionately from injuries.

Additionally, the cause and consequence of injuries vary considerably by age and developmental level, reflecting differences in children's cognitive, perceptual, and motor/language abilities, as well as the environment and exposure to hazards.

Children with special needs are likely to have a disproportionate share of these injuries considering their health status and lack of access to appropriate prevention education. These injuries have enormous financial, emotional, and social effects on not only the child and the family, but the community and society (Weiss et al, 1997).

Injury Costs

Injury is the leading cause of medical spending for children ages 5 to 14. (Children's Safety Network National Economics and Data Analysis Resource Center, 1998). The annual lifetime cost for injuries among children under the age of 20 is nearly $457 billion, which includes $20 billion in medical spending, $53 billion in future earnings lost, and $384 billion in quality of life improvement. Children with special health care needs are at unique risk for injury-related costs due to their complex pre-existing health status.

Injury Prevention Saves Money

Every child safety seat saves our country $85 in direct medical costs and an additional $1,275 in other costs by reducing the risk of death for infants by 71%, for toddlers by 54% and reducing the need for hospitalization in children under the age of five by 69%. Every bicycle helmet saves this country $395 in direct medical costs and other costs by reducing the risk of head injury by 85% and brain injury by 88%. Every smoke detector saves $35 in direct medical costs and an additional $865 in other costs to society by cutting the probability of dying in a residential fire in half (National SAFE KIDS Campaign). Finally, every dollar spent on poison control centers saves our country more than $6.50 in medical costs (Children's Safety Network National Economics and Data Analysis Resource Center, 1998).

Injuries Are Not Random Acts

In fact, injuries are both predictable and preventable incidents. Through a combination of education, environmental improvement, engineering modifications, enactment and enforcement of legislation and regulation, economic incentives, and community empowerment, the incidence and severity of injury-related death and disability can be reduced.

Risk Areas and Prevention Strategies for Children with Special Health Care Needs

Addressing injury prevention for children with special health care needs requires a thorough assessment of each child's unique risks. As with all children, it is important to conduct a simple assessment of the child's individual skills as well as their physical and social environment. This assessment should address the following areas: mobility, sensory-neuro, and cognitive abilities.
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Mobility: This includes assessment of how a child "gets around". An example of a mobility limitation is the child who uses special equipment such as a cane, walker, or wheelchair. It is important to understand each child's individual mobility skills and to assess the environment for potential hazards from a prevention perspective. These hazards may include clutter, steep ramps, or uneven surfaces. Some children may require additional equipment or supervision to help assure their safety

Sensory-neuro: Children with visual limitations, hearing loss, and decreased sensation as a result of their physical condition are placed in this category. This group of children may have a difficult time differentiating between hot and cold temperatures, which put them at risk at bath time, on a hot playground slide, or at work in a fast food restaurant setting.

Cognitive Limitations: Some children with cognitive limitations have difficulty understanding directions or staying with a group activity. They often need additional supervision and activities with more structure. It is important to provide both physical and verbal cues that help a child remember safety rules. (University of Colorado, 1996).

Regardless of their abilities, all children need and deserve to be safe. All parents should have the opportunity to receive information about home, school, work, and community safety initiatives. In addition, children with disabilities and their families should receive prevention information that addresses their unique needs and risks. After determining a child's risks, a plan for education, behavior, and environmental modification should be established to reduce or eliminate the child's risks.

The following chart provides examples of common prevention interventions and special concerns for children and adolescents with special health care needs. Many of the prevention interventions apply to all children.

Injury Prevention Interventions

Injury Mechanism	Education/Behavior Change	Enforcement/ Legislation	Environment/ Technology	Special Interventions for CSHCN
Motor Vehicle	Provide education to parents on correct child safety seat/booster seat and seatbelt use. Implement media campaign about correct use and positioning of child safety seats/booster seats, and seatbelts.	Promote the establishment and enforcement of primary restraint laws. Promote child safety seat and seatbelt laws. Conduct child safety seat checks. Encourage enforcement of DUI laws.	Distribute free child safety seats/booster seats to low income families. Reduce speed limits in neighborhoods with children. Install speed bumps.	Distribute special child safety seats/booster seats to CSHCN. Check seat temperature during hot weather to prevent burns. Assure proper positioning of child safety seats and booster seats.
Pedestrian	Counsel parents about traffic dangers, and provide pedestrian safety programs at elementary schools. Teach parents to practice safe walking routes with their child and encourage the use of reflective clothing.	Enact and enforce pedestrian right-of-way laws.	Improve lighting and crosswalks at problem inter-sections. Utilize crossing guards. Increase the use of reflective clothing.	Install curb cuts at crosswalks and audible crosswalk signals. Install surfaces to differentiate the street from the sidewalk. Mark safe places to stand while waiting for the bus. Identify children who need constant supervision when crossing streets.
Bicycle	Conduct bicycle safety rodeos at schools and community fairs; increase bicycle safety information in health curricula. Motivate parents to practice safe riding routes with their child. Promote use of bicycle helmets.	Promote bicycle helmet legislation; enforce current bicycle helmet laws.	Distribute free bicycle helmets to low income families; provide free bicycle repair workshops; increase number and quality of bicycle lanes and trails; distribute bike reflectors and flags.	Teach safe riding practices, including using the proper size bike and staying on trails or sidewalks. Enforce helmet use while in a racing wheelchair, rowcycle, or hand cycle. Advocate for production of smaller bike helmets.
Fires/Burns	Educate homeowners and rental property owners about anti-scalding devices and smoke detectors; encourage fire fighters to lead school assemblies on fire safety. Provide education on risks of smoking and keeping lighters and matches away from children and the safe use of candles, fireplaces, and grills.	Enforce building codes for smoke detector use; encourage building code regulators to require hot water heater settings below 120 degrees. Encourage fire fighters to check hot water temperature during home visits for smoke detector usage.	Promote the use of anti-scalding devices. Promote the use of smoke detectors and the importance of periodic battery testing and replacement.	Develop evacuation plans with appropriate exits. Install fire alarms that have flashing lights for children who are hearing impaired. Develop individualized evacuation plans for children that may have difficulty with changes in their environment.

Injury Mechanism	Education/Behavior Change	Enforcement/ Legislation	Environment/ Technology	Special Interventions for CSHCN
Home Hazards	Educate parents about gates and stairs; sharp-edged furniture; furniture near windows; proper crib construction; mini-blind cords; and storing poisons, medicines, and alcohol. Educate parents about installing window guards and moving furniture away from windows to prevent falls. Teach parents to not leave young children unattended.	Do not purchase mobile baby walkers that do not meet the U.S. Consumer Product Safety Commission's standards.	Distribute "no-choke" tubes to determine safe objects for small children, encourage increased availability and use of window guards and stair gates and distribute cabinet lock products.	Teach parents to remove unsafe objects and clutter, and cover glass edges and sharp corners on furniture. Avoid the use of loft beds of top bunk beds for a child with a seizure disorder, cerebral palsy, encephalopathy, etc Encourage use of bumber pads for cribs. Teach parents about correct sleeping positions.
Schools	Educate students and staff regarding potential hazards and prevention measures.	Inspect childcare facilities and schools for fall hazards and unsafe design features.	Maintain equipment and facilities (smoke detectors, lockers, playground and sports equipment).	Teach the appropriate use of wheelchair locks during transfers.
Work	Educate teens about their jobs, including safety procedures for each task and their rights. Provide teens and parents with education on child labor laws, hour restrictions and prohibited tasks. Teach and adolescents to comply with state regulations requiring work permit completion for teens.	Provide work and workplaces that comply with OSHA health and safety standards. Promote enforcement of child labor laws and workplace safety standards.	Provide workplaces that are free from hazards. Provide and use all safety equipment on the job as required.	Teens transitioning into the workforce may need special environmental orientation. Consider appropriate workplaces for adolescents, e.g. exposure to air pollution or second hand smoke may be a greater hazard for teens with asthma or cystic fibrosis.
Firearms	Develop a media campaign promoting trigger locks and lock boxes and encourage parents to remove guns from their homes.	Encourage restrictive licensing for handguns and enforcement of existing firearm laws.	Work with police on community policing initiatives; promote development of product safety modifications for handguns.	Teach parents to remove firearms from the home when a child is depressed and/or possibly suicidal.
Child Abuse and Other Violence.	Provide parent education programs to young and at-risk parents; develop self-help groups. Provide conflict resolution, anger management, and other prevention programs in schools and childcare facilities.	Work with local officials to maximize effectiveness of child protective services.	Support home visitor programs for new parents; provide affordable childcare.	Provide affordable childcare and respite care. Educate parents and siblings about behavior management and establishing regular sleeping patterns for children with special needs

Injury Mechanism	Education/Behavior Change	Enforcement/ Legislation	Environment/ Technology	Special Interventions for CSHCN
Playgrounds	Provide seminars on playground safety for school officials, teachers, park and recreation administrators, childcare providers, and parents.	Promote or mandate the use of CPSC standards for playground equipment and surfaces.	Support community development projects that improve play-ground equipment and surfaces	Install soft surfaces and accessible play space. Schedule individual or small group times on equipment.
Sports	Provide parents, students, and coaches with educational material on the proper sports equipment, skill development, and importance of physical conditioning.	Promote and mandate the use of proper safety equipment by school and community sports programs. Promote injury prevention training for coaches.	Promote the use of breakaway bases, mouth guards, and eye protection equipment.	Enhance individual skill development. Match sport activity to child's ability. Enforce the use of protective gear and follow appropriate game rules. Provide special protection for children who need to use assistive technology.
Drowning	Provide information to pool owners about drowning risks and appropriate pool barriers. Educate parents about the risks of bathtubs, open toilets, and buckets. Provide education on open water drowning risks. Encourage parents to learn CPR.	Establish and enforce pool barrier codes for home, community, and public pools.	Promote use of pool barriers, including four-sided isolation fencing with self-closing and self-latching gates. Promote use of personal floatation devices.	Use supervision. Teach swimming skills and water safety. Swim with a buddy and only in areas with lifeguards on duty. Protect skin from rough surfaces (wear socks).

Coalition Building

The complex nature of injuries and the multiple factors involved with each injury incident require a multi-dimensional approach to prevention. Effective prevention interventions involve the use of education, enforcement, and environmental changes, as well as the cooperation of numerous individuals, agencies, and organizations. Collaboration and coalition building are key to developing effective injury prevention interventions.

State and local public health agencies, both for children with special health care needs and injury prevention, are key partners in injury prevention initiatives. Making contact with these agencies should be a first step to organizing a collaborative injury prevention initiative and to determine what initiatives already exist.

Most communities have one or more networks of organizations that address childhood injury prevention. The most common participants include:

- City and/or county departments of health
- Children's hospitals and regional medical centers
- Schools
- SAFE KIDS coalitions
- Law enforcement organizations
- Fire departments and EMS professionals
- Local chapters of the American Academy of Pediatrics
- Civic groups (Kiwanis Clubs, Junior Leagues, etc.)
- Red Cross chapters
- YMCA and YWCA chapters

Individuals interested in injury prevention will serve as a foundation for effective interventions. Additional partners for childhood injury prevention include:

- Local and state safety councils
- Injury prevention research centers
- Universities or institutions of higher education
- Business community
- Non-profit organizations (MADD, Consumer Groups, PTA, etc.)
- Religious communities
- Foundations
- Child care providers
- Sport organizations
- Local medical societies
- Media

For more information on the Injury Prevention for Children with Special Health Care Needs Work Group, contact the EMSC National Resource Center at (202) 884-4927 or via e-mail at info@emscnrc.com.

The Work Group included representatives from the following agencies and organizations:

- American Academy of Pediatrics
- American Speech-Language-Hearing Association
- American Occupational Therapy Association
- American Physical Therapy Association
- Center for the Prevention of Disabilities
- Children's Safety Network
- Consortium for Citizens with Disabilities
- EMSC National Resource Center
- Family Voices
- Maternal and Child Health Bureau, Health Resources and Services Administration
- James Whitcomb Riley Hospital for Children at Indiana University School of Medicine
- National Highway Traffic Safety Administration
- National SAFE KIDS Campaign
- Spina Bifida Association of America
- TBI Technical Assistance Center

References

CDC, National Mortality Data: 1995. Centers for Disease Control and Prevention, Public Health Service, USDHHS, Atlanta, GA, 1998

Children's Safety Network Economics and Insurance Resource Center, Childhood Injury: Cost & Prevention Facts, Rockville, MD, 1997.

National SAFE KIDS Campaign, Fact Sheets, Washington, DC, 1998.

University of Colorado, School of Nursing, Safe at School: Planning for Children with Special Needs (video), Colorado, 1996.

Weiss, H., Child and Adolescent Emergency Data Book, Pittsburgh, PA: University of Pittsburgh, 1997.

Emergency Information Form for Children With Special Needs

Last name:

American College of Emergency Physicians*

American Academy of Pediatrics

Date form completed	Revised	Initials
By Whom	Revised	Initials

Name: Birth date: Nickname:

Home Address: Home/Work Phone:

Parent/Guardian: Emergency Contact Names & Relationship:

Signature/Consent*:

Primary Language: Phone Number(s):

Physicians:

Primary care physician: Emergency Phone:

Fax:

Current Specialty physician: Emergency Phone:
Specialty:

Fax:

Current Specialty physician: Emergency Phone:
Specialty:

Fax:

Anticipated Primary ED: Pharmacy:

Anticipated Tertiary Care Center:

Diagnoses/Past Procedures/Physical Exam:

1. Baseline physical findings:

2.

3. Baseline vital signs:

4.

Synopsis:

Baseline neurological status:

*Consent for release of this form to health care providers

Last name:

Diagnoses/Past Procedures/Physical Exam continued:

Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1.	
2.	
3.	
4.	Prostheses/Appliances/Advanced Technology Devices:
5.	
6.	

Management Data:

Allergies: Medications/Foods to be avoided	and why:
1.	
2.	
3.	
Procedures to be avoided	**and why:**
1.	
2.	
3.	

Immunizations

Dates					
DPT					
OPV					
MMR					
HIB					

Dates					
Hep B					
Varicella					
TB status					
Other					

Antibiotic prophylaxis: Indication: Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: Print Name: